AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

**Re: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital**

Dear Acting Administrator Slavitt:

The physician and medical student members of the American Medical Association (AMA) thank you for allowing continued discussion and comment on the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems final rule. We appreciate and support many of the changes the Centers for Medicare & Medicaid Services (CMS) made in the final rule, including a 90-day EHR reporting period in 2016 for physicians, reduced measure and threshold requirements in the Medicare Meaningful Use program in 2017 and subsequent years, and the creation of a hardship exemption for new participants in the Medicare Meaningful Use program in 2017. However, we strongly believe that CMS should make changes to address several shortcomings in the final rule, outlined below.

The AMA has serious concerns regarding CMS' discussion of the methodology used to scale OPPS payment data to establish payment rates in the Medicare Physician Fee Schedule (MPFS) for nonexcepted off-campus outpatient Provider-Based Departments (PBDs). Using OPPS data in the MPFS rate setting in future years could be extremely problematic. We also have significant concerns with language in the final rule that makes comparisons between the MPFS and Ambulatory Payment Classification (APC) rates. We strongly believe that the physician fee schedule data, as developed through the AMA/Specialty Society RVS Update Committee (RUC) process, are the most accurate and granular payment data available today. In addition, while we strongly support the removal of the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey for the purpose of the VBP Program, we have concerns about CMS' recent efforts to develop new pain measures for the program. We provide detailed comments below on these issues, and urge CMS to work with the AMA and other stakeholders going forward to improve these policies.

<u>Establishment of MPFS Payment Rates for Nonexcepted Outpatient Provider-Based Departments</u>

Section 603 of the Bipartisan Budget Act of 2015 prohibits CMS from continuing to pay hospitals the OPPS rates for services furnished in outpatient PBDs beginning January 1, 2017, with some exceptions. In the rule, CMS finalizes a policy to establish payment rates under the MPFS for nonexcepted items and services furnished on or after January 1, 2017. Specifically, CMS establishes site-specific rates under the MPFS for the technical component of items and services furnished by nonexcepted off-campus PBDs that are based on the OPPS payment amount for these same services, scaled downward by 50 percent.

CMS uses 25 high-volume codes to estimate a percentage to use in scaling OPPS rates to MPFS payment rates for services at nonexcepted off-campus departments. CMS' analysis resulted in an average reduction of OPPS rates by 45 percent. In addition, CMS considered that broader ASC rates are reduced by approximately 55 percent. This methodology is problematic and will result in MPFS rates that will be 50 percent of the OPPS payment amount for the same services. The AMA has routinely commented that we believe current ASC rates are set too low and do not accurately portray the cost for providing services. In addition, this methodology overly simplifies the development of an entirely new payment system that bypasses the use of any clinical or specialty society input.

Use of OPPS Payment Rate Data in MPFS Ratesetting

In the discussion regarding the establishment of payment rates for nonexcepted off-campus PBDs, CMS states:

> We have long acknowledged our concerns regarding some of the information currently used to develop RVUs for payment rates under the MPFS (for example in the CY 2015 MPFS final rule with comment period (79 FR 67568)). We believe that, for nonexcepted items and services furnished by an off-campus PBD, the quality of data currently used to develop payment rates under the OPPS, including hospital claims data and cost reporting, far exceeds the quality of data currently used for MPFS payments. In fact, the narrower the gap between the OPPS and MPFS packaging and billing rules and/ or the better we are able to estimate the effect of that gap, the greater the potential would be to utilize the OPPS data in the MPFS ratesetting in future years.

The AMA strongly disagrees with this statement. The discussion below outlines the issues with using OPPS payment data in MPFS ratesetting and why accurate comparisons cannot be made between MPFS and APC payment rates.

**OPPS Payment Rate Data Issues**

**The AMA has significant concerns regarding CMS' statements suggesting that the quality of OPPS payment rates far exceed the quality of data used for MPFS payments**. As we have stated in previous letters and discussions with CMS, we continue to believe medicine is a very complicated and rapidly changing field that makes significant clinical input into the definition and valuation of physician services a necessary ingredient of any payment system. Therefore, we do not believe the need for ongoing clinical input can be eliminated by replacing Medicare's current physician payment system with one that relies on hospital or OPPS cost data and averages payments across an array of procedures. We believe that the RUC has provided, and should be encouraged to continue providing, needed clinical expertise in the design and maintenance of Medicare physician payment systems.

CMS provides no data to support their stated belief that OPPS payment data may be more accurate than MPFS payment rates. Critics of the RUC have previously claimed that its process is not "robust," and that specialty societies participating in the RUC process can essentially dictate the value of their services. Neither claim is accurate. In fact, the rigor of the RUC process and the objectivity and clinical expertise of its 300 participating members, advisers, and specialty staffers matches that of any other CMS advisers and contractors and exceeds that of most. Extensive conflict of interest rules govern the survey process, presentation of specialties' recommendations, and participation of RUC members in deliberations regarding recommendations involving their specialty. In some cases, costs of increased values or new codes are offset through reductions in the values of related services. In other instances, these costs must be financed through cuts in unrelated services or an across-the-board reduction in the conversion factor. Most important perhaps is the fact that decisions are made by a cross-specialty panel of 31 physicians and other health care professionals, all of whom are well aware that they work in a budget neutral environment where any new services or value increases in one area may reduce payments for their own services, essentially eliminating the opportunity for any given RUC member to benefit financially from a vote on his or her own services. Though most of the 300+ attendees at RUC meetings are RUC members and participants, with advance notice to RUC staff, virtually anyone is allowed to observe the proceedings—something that no other contractor providing paid advice to CMS can say.

In addition, in its nearly 25 years of operation, the RUC has initiated an increasingly sophisticated and objective process for reviewing services. For example:

- The RUC is moving to a centralized on-line survey tool and now requires at least 75 surveys for services performed more than a million times a year, 50 surveys for those done 100,000 to 999,000 times a year, and 30 surveys for less frequently performed services. This is significantly higher than the 20-case minimum CMS uses in most of its physician performance measures.
- Standard resource packages to describe procedure pre- and post- time have also been created to inject more uniformity into valuation of various service categories.
- The RUC has also initiated a process to identify potentially misvalued codes using screens that address many issues that have been raised by CMS and others. For example, new technology codes are now routinely reviewed at set periods of time; codes with high volume growth, high intensity, and site of service changes have all been reviewed and revalued. Codes for services normally done together were also revised, reviewed, and revalued so that any duplication of resources within the codes' values was removed.
- Since the inception of this effort in 2006, some 2,235 services have been identified through 16 different screening criteria. To date, the RUC has recommended reductions and/or deletions for 1,225, thereby redistributing more than $4 billion to other services, including $1 billion for the new transitional and chronic care codes. Another 265 codes are still under review. Excluding E&M services, which policymakers have indicated they do not believe are overvalued, codes for services responsible for all but 12 percent of Medicare spending on physician services have been reviewed.

The AMA believes the MPFS data developed through the RUC process are significantly more accurate than OPPS payment rates, and urges CMS not to utilize OPPS data in setting physician fee schedule rates in the future.

**Comparisons Between MPFS and APC Payment Rates are Flawed**

CMS should also refrain from making comparisons between the MPFS and APC payment rates, since comparing an average payment to precise services often results in improper payments, with some services being overpaid and other services receiving insufficient reimbursement. For example, as we discussed in our comment letter on the OPPS proposed rule, we believe there are significant data issues in CMS' restructuring of the APC groups. In response to a 2013 proposal from CMS, RUC members examined the use of APCs to help guide payments to physicians, an idea that was viewed as a means of simplifying maintenance of the physician fee schedule and reducing the workload at CMS. A variety of problems with this approach were discovered, including:

- The underlying premise of the APCs is that some services will be paid at rates that are higher than costs while others will be paid at rates that are lower than costs. In a hospital with a large number of patients, profits on some services will generally offset losses on others. It cannot be assumed that the same principle applies to physicians, who generally have fewer patients and are more specialized in the care they provide than hospitals.
- Although the data underlying the APCs is often portrayed as highly accurate due to the fact that it is collected from hospital cost reports, significant questions have been raised about the underlying data used in these reports. CMS itself noted in 2013 that it was considering requiring hospitals to break out charges for provider-based departments as outpatient service cost centers because currently "this practice is not consistent or standardized." Rates in the system also can swing by 10 percent to 20 percent a year based on the mix of hospitals included in the calculation of APCs in a given year, especially for low volume OPPS services.
- For services performed predominantly in a physician's office, hospitals often do not have good cost data. In some cases, the supplies and equipment included in physician payments are not reflected in the APC data. As happened this year in proposed reductions in OPPS payment rates for lung screening, data for new services is often incomplete or missing.
- Even when the data is accurate, APC rates based on a weighted average that reflects frequency of services in the hospital outpatient setting often do not accurately depict the cost of services that are not often done in that setting. This is not a minor problem. Nearly 2,000 CPT® codes, representing nearly half of physician spending ($40 billion in allowed charges), are done either 90 percent of the time in the physician office (650 codes) or 90 percent of the time in an inpatient setting (1,300 codes). OPPS data would in no way represent the typical resources required to provide these services in a physician's office
- A prime example of how these site-of-service differences affected rates at the time of CMS' unsuccessful 2013 proposal can be found in a chemotherapy APC in which one code that did not involve infusion and paid $75 when done in a physician's office made up 90 percent of the hospital-performed services in the APC. Another far more complex and resource-intensive code in the APC involving pleural cavity chemotherapy with infusion and thoracentesis, was paid at $806 in the physician setting and included a disposable catheter invoiced at $329. The resulting APC payment rate of $146 clearly would have been insufficient in many physician practices.

Issues such as these illustrate the AMA's continued concerns that the use of hospital cost data does not guarantee accuracy of payments, and that clinical judgment and expertise are necessary ingredients in the determination of Medicare payment rates.

While we generally agree that a properly structured comparison of OPPS and physician fee schedule rates might be an appropriate screen to identify services for review as potentially misvalued, the AMA is confident that the physician fee schedule data is the most accurate and granular available today. These data is based on credible surveys and have undergone an extensive cross-specialty review that exceeds the standards of most, if not all, other analyses of physician resource use. While it is true that maintaining and updating these data is a significant undertaking, we believe that creating appropriate values for all services cannot be achieved without a mechanism that involves early and significant clinical input from across medicine. The RUC has filled that role successfully for a quarter century with volunteer physicians and other health care professionals who have devoted substantial hours of time and saved the government millions of dollars.

Removal of Hospital Value-Based Purchasing Program and Inpatient Quality Reporting (IQR) Program Pain Measures

The AMA has repeatedly called for the removal of the HCAHPS pain questions, and fully supports CMS' decision to eliminate the pain management questions from the Hospital VBP and IQR programs. We believe pain management questions should not be used in a program where there is a link between scoring well in the program and higher payments to hospitals. In multiple previous comment letters, the AMA has urged CMS to remove the questions from the Hospital VBP program due to physicians voicing strong concern that the pain-related questions in the HCAHPS survey have had the unintended consequence of promoting the over-prescribing of opioids, thereby contributing to the epidemic of opioid misuse, overdose, and death currently occurring across the country.

CMS states in the rule that they are currently developing alternative questions for the Pain Management dimension. Our review of the pain measures that were placed on the 2016 Measure Application Partnership (MAP) Measure Under Consideration List generated significant concerns about their use. The following questions would replace the current Pain Management measure in the HCAHPS survey with a new measure:

- **Communication about Pain During the Hospital Stay (MUC16-263)**
    - Multi-item measure (composite): HP1: "During this hospital stay, did you have any pain?" HP2: "During this hospital stay, how often did hospital staff talk with you about how much pain you had?" HP3: "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?" HP4: "During this hospital stay, did you get medicine for pain?" HP5: "Before giving you pain medicine, did hospital staff describe possible side effects in a way you could understand?"

- **Communication about Treating Pain Post-Discharge (MUC16-264)**
    - Multi-item measure (composite): DP1: "Before you left the hospital, did someone talk with you about how to treat pain after you got home?" DP2: "Before you left the hospital, did hospital staff give you a prescription for medicine to treat pain?" DP3: "Before giving you the prescription for pain medicine, did hospital staff describe possible side effects in a way you could understand?"

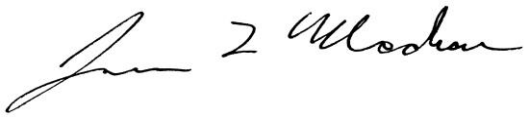
The questions as drafted still highlight prescription medications as the sole option for managing pain when alternatives may also be effective, such as physical therapy or nonprescription medications. The questions associated with MUC 16-263, Assessing Pain During the Actual Patient Stay are also open-

ended. The second and third question associated with Measure MUC16-263, HP2: "During this hospital stay, how often did hospital staff talk with you about how much pain you had?" and HP3: "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?" are not realistic since scoring requires that the patient replies "Always" in order to get credit. We also suggest that instead of asking whether hospital staff explained "side effects" of any prescribed pain medications, the question should ask if hospital staff explained how to safely use the medication. Therefore, **we urge CMS to consult with relevant stakeholders, including the AMA, before moving forward with incorporating new pain measures into the IQR or VBP programs to ensure the measures do not have negative consequences on physicians' ability to exercise their best judgment when providing patient care.**

There is also a need for CMS to complete testing, consult with the physician community, and bring the measures back to the MAP for careful review after the testing results and revised measures are developed to ensure the results are valid and the measures do not lead to unintended consequences. A sufficiently tested, methodical approach will ensure better measures are developed.

We appreciate the opportunity to provide feedback on the OPPS final rule. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD